

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-028107

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4038

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED AUG 6 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in lb Life		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3214 Harrison		d. STREET ADDRESS (If outside, give location) 3214 Harrison	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EARL E ALDRICH			
4. DATE OF DEATH Month Day Year July 18 1963			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-12-1882
9. AGE (last birthday) 81		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (City and state or country) Lee Summit, Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME George Aldrich		13b. MOTHER'S MAIDEN NAME Adelle Shepard	
14. NAME OF HUSBAND OR WIFE Ellen F. Aldrich		Address 3214 Harrison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Mrs. Ellen Aldrich		Address 3214 Harrison	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). ARTERIO SCLEROTIC HEART DISEASE PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 1958 7/18/63	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 7/17/63	
20f. CITY, TOWN, OR LOCATION Lee's Summit, Mo.		COUNTY STATE	
21. I attended the deceased from 1958 to 7/18/63 and last saw her/him alive on 7/17/63 Death occurred at 4:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Leo F. Cooper MD		22b. ADDRESS 4220 J.C. Nichols Pkwy KC Mo	
22c. DATE SIGNED 7/18/63		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 7-20-1963		23c. NAME OF CEMETERY OR CREMATORY Lee's Summit Cemetery	
23d. LOCATION (City, town, or county) Lee's Summit, Mo.		23e. DATE RECD. BY LOCAL REG. 7-18-63	
24. FUNERAL DIRECTOR Muehlebach		25. ADDRESS 6800 Troost	
26. REGISTRAR'S SIGNATURE Ruth Long		27. ADDRESS	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION
Leo F. Cooper

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Robert L. Landes

Licensed Embalmer No. 5103

P. O. Address K.C., Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

* If this body is not embalmed, fact should be so stated above.